Assessment of payment adequacy: Inpatient rehabilitation facilities

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Inpatient rehabilitation facilities

- Provide intensive rehabilitation (physical, occupational, speech therapy)
- $6.2 billion Medicare spending in 2006
- Medicare accounts for ~70% of IRF patients
- PPS established for IRFs in 2002, pursuant to BBA

IRF criteria

- Patients generally must meet 3-hour rule
- IRFs must:
  - Meet acute hospital COPs
  - Meet other conditions
    - Medical director must provide care full-time
    - Preadmission screening
    - Multidisciplinary team approach
    - Nurses must specialize in rehabilitation
    - 75% rule

75 percent rule

- 75% of all patients must have specific diagnoses
- IRFs not in compliance are paid acute hospital rates for all Medicare patients
- Phase-in of renewed enforcement of the 75% rule:
  - 50% July 2004-June 2005
  - 60% July 2005-June 2007
  - 65% July 2007-June 2008
  - 75% beginning July 1, 2008
- 2004 change means most hip and knee replacement patients not appropriate for IRFs

Assessing adequacy of Medicare payments for IRF services

- Supply of facilities (including supply of beds)
- Volume of services / access to care
- Quality of care
- Access to capital
- Payments and costs
  - emphasis on the costs of the efficient provision of care (MMA Section 735)

Supply of IRFs stable, 2004 - 2006

	2002	2004	2006	Annual change 2002-04	Annual change 2004-06
All IRFs	1,188	1,227	1224	1.6%	-0.1%
Urban	988	1,009	969	1.1	–2.0
Rural	200	218	255	4.4	8.2
Nonprofit	755	772	757	1.1	–1.0
For profit	277	294	299	3.0	0.8
Freestanding	215	217	217	0.5	0.0
Hospital-based	973	1,010	1,007	1.9	-0.1

Source: MedPAC analysis of provider of services data from CMS.

Supply of IRF beds declined

	2002	2004	2006	Annual change 2002-04	Annual change 2004-06
Total beds	35,859	36,770	35,290	1.8%	-2.0%
Free-standing	13,321	13,117	12,424	1.6	-2.7
Provider-based	22,538	23,653	22,866	2.0	-1.7

Source: MedPAC analysis of Medicare hospital cost reports from CMS.

Volume and spending rapidly increased after PPS, followed by volume declines

	2002	2004	2006	Annual Change 2002-2004	Annual Change 2004-2006
Cases	440,000	497,000	404,000	6.3%	–9.8%
Cases per 10k beneficiaries	126	137	113	4.2%	-9.0%
Payment per case	$11,152	$13,275	$15,354	9.1%	7.5%
Spending (billions)	$4.5	$6.0	$6.2	15.5%	1.7%

Source: MedPAC analysis of Medicare IRF claims from CMS; spending estimates from CMS Office of the Actuary.

Change in composition of Medicare IRF cases, 2004 - 2007

	Percent			
Diagnosis	**2004**	**2005**	**2006**	**2007**
Stroke	11.6	15.0	20.4	20.8
Fracture of the lower extremity	8.8	11.4	16.9	17.1
Major joint replacement	30.3	25.7	17.9	15.5
Neurological disorders	6.4	7.3	7.0	7.4
Brain injury	4.8	6.3	6.1	6.6
Other orthopedic conditions	6.4	6.1	5.2	5.4
Spinal cord injury	5.1	5.2	4.6	4.4
Cardiac conditions	6.4	5.0	3.9	4.2
Burns	0.0	0.0	0.1	0.1
Other	20.1	17.8	17.9	18.5

Source: MedPAC analysis of IRF-PAI data from CMS.
Note: 2007 data are January – June only.

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Implications for FFS beneficiaries' access to care

- Do declines in IRF utilization suggest access problem?
- Hip and knee replacement example:

Discharge destination	2004 Volume	2004 Share	2006 Volume	2006 Share	Change in volume, 2004 – 2006	Change in share, 2004 – 2006
IRF	130,400	28%	95,600	20%	-27%	-30%
SNF	150,400	33%	169,000	35%	12%	8%
Home health	98,000	21%	130,700	27%	33%	28%
Other	83,200	18%	86,500	18%	4%	0%
Total	462,000	100%	481,800	100%		

Source: MedPAC analysis of hospital MEDPAR data from CMS, 2004 – 2006.

Quality of care: improvement in functioning, discharge v. admission, 2004-2007

	Change in FIM™ Score			
Medicare patient type	2004	2005	2006	2007
All	22.8	23.2	23.5	23.8
Percent change		4.0	4.0	1.8
Discharged home	25.0	26.0	27.0	27.5
Percent change		4.0	1.1	1.4

Source: MedPAC analysis of IRF-PAI data from CMS, 2004 – 2007.
Note: 2007 data is January – June. "All" includes patients discharged to other inpatient settings, other post-acute care, outpatient care, and home.

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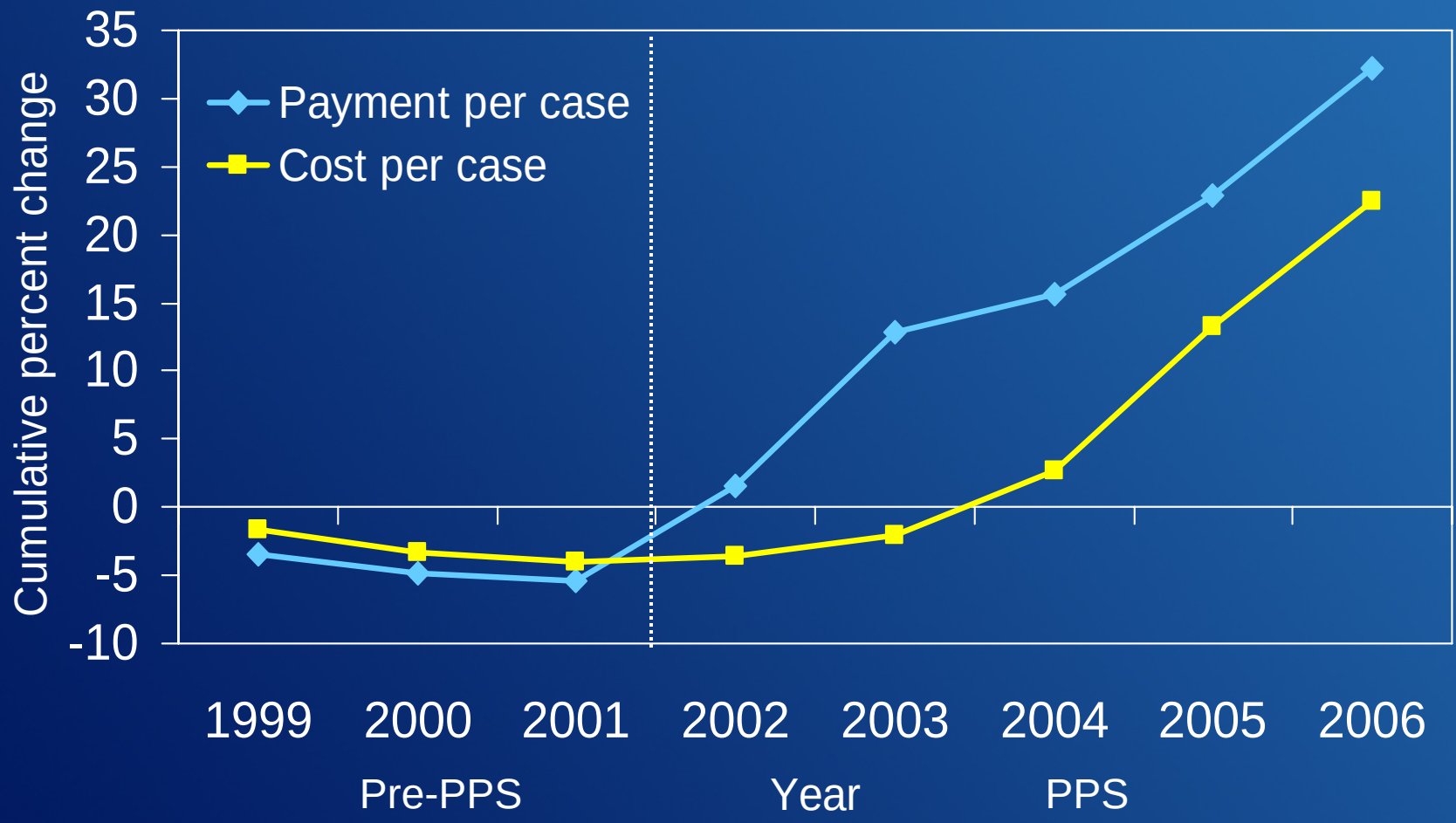
IRFs' access to capital is mixed

- 80% of IRFs are hospital-based and access capital through parent
- Freestanding IRFs: large chain providers may be facing difficulty accessing capital

Cumulative changes in IRFs' payments and costs per case, 1999-2006



Source: MedPAC analysis of Medicare hospital cost reports from CMS.

Change in IRF criteria (75% rule)

Old "HCFA-10"Conditions

1. Stroke
2. Brain injury
3. Amputation
4. Spinal cord
5. Fracture of the femur
6. Neurological disorders
7. Multiple trauma
8. Congenital deformity
9. Burns
10. **Polyarthritis**

New CMS-13 Conditions

1— 9 Same as "HCFA 10"

10. **Osteoarthritis**
    - After less intensive setting
11. **Rheumatoid arthritis**
    - After less intensive setting
12. **Joint replacement**
    - Bilateral
    - Age ≥85
    - Body Mass index >50
13. Systemic vasculidities
    - After less intensive setting

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